

**INSURANCE ASSISTANCE  
PROGRAM REDETERMINATION**  
Michigan Department of Health and Human Services

**To remain eligible you must complete this form and return it in 30 days. Failure to return this form in 30 days will result in delay in your insurance payment or cancellation from the insurance assistance program.**

1. Recipient Name		
2. Address		
3. City	4. State	5. Zip
6. County	7. Social Security Number	
8. Date	9. Telephone No.	

**ANSWER ALL QUESTIONS LISTED BELOW**

**EMPLOYMENT INCOME** Answer all questions that apply to your employment and submit income verification.

10. Are you employed or self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶ If yes, complete items 11-25 below.				
If you are Currently Working List Employer(s) Name	Number of Hours Per Week	Wages Before Deductions	How Often Paid: Weekly, Every 2 Weeks, Twice a Month, Monthly, Other	Is Health Insurance Available Through Your Employer
11.	12.	13.	14.	15. <input type="checkbox"/> Yes <input type="checkbox"/> No
16.	17.	18.	19.	20. <input type="checkbox"/> Yes <input type="checkbox"/> No
21.	22.	23.	24.	25. <input type="checkbox"/> Yes <input type="checkbox"/> No

**OTHER INCOME** Check all that apply and submit income verification.

26. Do you Receive Money From:	\$	27. If Yes, Give Monthly Amount	28. Who Receives?
<input type="checkbox"/> Social Security Benefits	\$		
<input type="checkbox"/> Veteran's Benefits	\$		
<input type="checkbox"/> Unemployment or Workers' Compensation	\$		
<input type="checkbox"/> Disability Benefits Long Term and Short Term	\$		
<input type="checkbox"/> Do you Receive Money From:	\$		
<input type="checkbox"/> Child Support	\$		
<input type="checkbox"/> Retirement Benefits	\$		
<input type="checkbox"/> Spouse's Income	\$		
<input type="checkbox"/> Other Income (Please explain)	\$		

29. If you are currently working and you are eligible for an employer sponsored health insurance, what is the date you will become eligible?  
(Please List Date) \_\_\_\_\_

**ASSETS:** Check off all that apply and submit verification. Include assets held jointly.

ASSET TYPE					
<input type="checkbox"/>	32. Do you have any of the following accounts:	33. Name(s) on the Account	34. Name and Address of Bank, Credit Union, Savings and Loan	35. Account Number	36. Balance as of Current Date
<input type="checkbox"/>	Checking/Draft Accounts				\$
<input type="checkbox"/>	Money Market				\$
<input type="checkbox"/>	Savings/Share Accounts				\$
<input type="checkbox"/>	Certificates of Deposit (CD)				\$
				Amount/Value	Owner(s)
<input type="checkbox"/>	Cash on Hand or in Safe Deposit Box				
<input type="checkbox"/>	Savings Bonds, Stock or Mutual Funds				
<input type="checkbox"/>	IRA, KEOGH, 401K or Deferred Compensation account(s)				
<input type="checkbox"/>	Trust Funds, Land Contracts, Real Estate (not including your home)				
<input type="checkbox"/>	Other Assets (List)				
<input type="checkbox"/>					

**I certify, under penalty of perjury, that all the information that I have written on this form or told to a caseworker is true.**

<b>30. Print Applicant Name</b>	
Applicant Signature	Date

Case Manager, if applicable (Print Name)	Agency
Phone Number	Email

Redetermination forms should be mailed to the address below or **faxed to 517-335-7723**.

**Michigan Department of Health and Human Services**

**Insurance Assistance Program**

**109 W. Michigan Avenue, 9<sup>th</sup> Floor**

**Lansing, MI 48913**

**If you have any questions, please call 877-342-2437.**

This form is issued under authority of 45 CFR 206.10(a)(1)(ii); 42 CFR 435.907i; CFR 273.2(d); and Sections 24, 25, and 59 Act 280 of the Public Acts of 1939, as amended. You must complete this form if you want the agency to consider your re-application for the insurance assistance program.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
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